C1 SPINE LAB

PATIENT REGISTRATION & CONSENT

1. About You

Legal name (Last, First, Middle):	Preferred name:
Date of birth (MM/DD/YYYY):	Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex
Street address:	City / State / ZIP:
Mobile phone:	Email:
Emergency contact (name / relationship):	Emergency contact phone:

☐ Preferred contact: Phone ☐ Preferred contact: Text ☐ Preferred contact: Email ☐ Marital status (optional): _____

2. Today's Concern

Main reason for today's visit _____

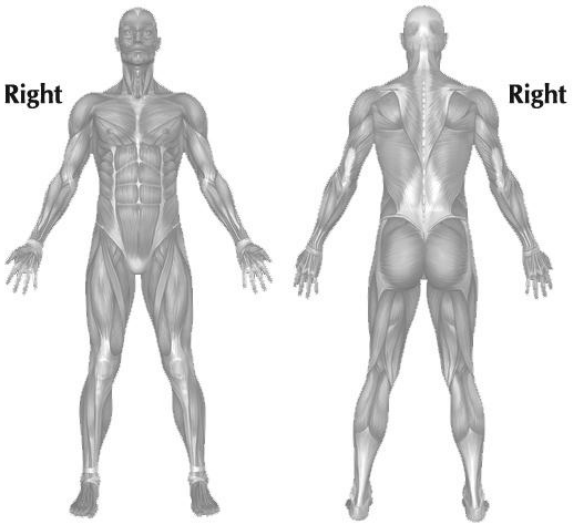
When did it begin?	Pain now (0–10):	Worst pain (0–10):
What makes it better?	What makes it worse?	Is it changing? ☐ Better ☐ Worse ☐ Same

☐ Neck pain
☐ Dizziness / vertigo
☐ Shoulder / arm pain
☐ Low back pain
☐ Balance difficulty
☐ Headache / migraine
☐ Jaw / facial symptoms
☐ Numbness / tingling
☐ Hip / leg pain
☐ Other: _____

What activities, work, sleep, or daily tasks are affected? _____

3. Symptom Map

Mark all affected areas and label the sensation.



Use: A = aching B = burning
N = numbness P = pins/needles
S = sharp W = weakness

Does pain travel? ☐ No ☐ Yes
If yes, from: _____
to: _____

Additional notes:
_____
_____
_____

4. Health History

Check current or past conditions. Add details where requested.

- ☐ High / low blood pressure
- ☐ Pacemaker / implanted device
- ☐ Bleeding disorder / blood thinner
- ☐ Osteoporosis / bone weakness
- ☐ Seizure / fainting / loss of consciousness
- ☐ Kidney disease
- ☐ Autoimmune / inflammatory condition
- ☐ Numbness / progressive weakness
- ☐ Vision / speech change
- ☐ Anxiety / depression
- ☐ Heart disease / chest pain
- ☐ Stroke / TIA / blood clot
- ☐ Cancer / tumor
- ☐ Recent fracture / major trauma
- ☐ Diabetes
- ☐ Liver disease
- ☐ Current infection / fever
- ☐ Bowel or bladder control change
- ☐ Unexplained weight loss
- ☐ Other significant condition

Please explain any checked condition(s) _____

5. Medications, Allergies & Procedures

Current medications and supplements (include dose if known) _____

Medication, latex, or adhesive allergies and reaction _____

Surgeries, hospitalizations, fractures, or implants (type and year) _____

Primary care clinician / practice:	Phone (if known):
Other specialists currently treating you:	Reason:

6. Chiropractic & Injury History

Prior chiropractic care? ☐ No ☐ Yes – last visit / provider:	Result: ☐ Helped ☐ No change ☐ Worse
Prior spine disorder or treatment? ☐ No ☐ Yes – explain:	Use cane, brace, heel lift, or assistive device? ☐ No ☐ Yes
Current concern related to an accident or injury? ☐ No ☐ Yes	Date: _____ Type: ☐ Auto ☐ Work ☐ Home ☐ Other

If accident/injury, briefly describe what happened _____

Pregnancy / imaging safety If you could be pregnant, tell the doctor before any X-ray or modality. ☐ Not applicable ☐ No possibility ☐ Possible / pregnant

Urgent symptoms Tell the doctor immediately about new severe headache, chest pain, trouble speaking, fainting, sudden weakness, loss of bowel/bladder control, or other rapidly worsening symptoms.

7. Proposed Care

C1 Spine Lab may recommend a chiropractic history and examination, orthopedic or neurologic testing, posture or range-of-motion assessment, diagnostic imaging when clinically appropriate, chiropractic adjustments (including upper-cervical procedures), soft-tissue or mechanical therapy, therapeutic exercise, and certified electrical or therapeutic modalities. Only clinically appropriate services will be provided, and you may ask questions or decline any procedure.

8. Expected Benefits, Material Risks & Alternatives

Expected benefits. Chiropractic care is intended to improve joint motion and function and may reduce pain, muscle tension, or related symptoms. Results cannot be guaranteed.

Common or temporary effects. Soreness, stiffness, fatigue, dizziness, headache, bruising, or a temporary increase in symptoms may occur.

Less common or serious risks. These may include sprain/strain, aggravation of an existing condition, disc injury, fracture (especially with weakened bone), nerve injury, burns or skin irritation from a modality, and other injury. Serious neurologic injury or stroke after cervical manipulation has been reported and is very rare; the nature and degree of causal association remain debated. Tell the doctor immediately about unusual or worsening symptoms.

Alternatives. Reasonable alternatives may include no treatment, watchful waiting, evaluation by another chiropractor or other health professional, physical therapy, medication, injection, surgery, or another treatment approach. Choosing no care or delaying referral may allow a condition to persist or worsen.

Clinical judgment and referral. The doctor will determine whether proposed care is appropriate based on the available history, examination, and imaging. C1 Spine Lab may modify care or refer you when a condition appears outside chiropractic scope, training, or experience.

9. X-Ray & Modality Safety

X-rays. If imaging is recommended, the doctor will explain its purpose. X-rays involve ionizing radiation. C1 Spine Lab uses clinical judgment and reasonable exposure reduction. Inform us before imaging if pregnancy is possible.

Shortwave diathermy / therapeutic heat. Do not receive this therapy over or near metal or electronic implants, a pacemaker, malignancy, active bleeding, severe circulation or sensation impairment, acute infection, open wounds, or pregnancy. Remove metal jewelry and clothing items as directed and report excessive heat immediately.

PEMF / BEMER or other electrical modalities. Disclose pacemakers, defibrillators, neurostimulators, drug pumps, other active implants, pregnancy, serious cardiac conditions, bleeding risk, malignancy, or other major medical conditions before use. Device-specific precautions will be reviewed when applicable.

Your choice You may ask questions at any time, request an explanation of a recommended procedure, refuse a particular procedure, or withdraw consent for future care. Withdrawal does not affect care already provided.

10. Questions for the Doctor

Questions or concerns you want addressed before care _____

_____

_____

11. Self-Pay Financial Agreement

C1 Spine Lab operates as a self-pay clinic. The clinic does not participate in-network with, verify benefits for, bill, file claims with, or accept assignment from private commercial insurance, Medicaid, workers' compensation, or any other third-party payers. Payment is due in full at the time of service.

Payment is due at the time services are provided unless C1 Spine Lab approves a written payment arrangement in advance. I am responsible for all charges, including services related to an accident, work injury, or legal matter, regardless of any expected reimbursement or settlement.

The clinic will explain fees before non-emergency services and may provide an itemized receipt upon request. If I choose to seek reimbursement independently, I am responsible for determining eligibility and submitting any documentation. C1 Spine Lab does not promise reimbursement.

I authorize reasonable collection activity for unpaid balances and agree to pay returned-payment and collection charges only to the extent disclosed and permitted by law. Questions about charges should be raised promptly with the clinic.

12. Notice of Privacy Practices

I acknowledge that C1 Spine Lab made its Notice of Privacy Practices available to me. The Notice explains how health information may be used or disclosed, my privacy rights, and whom to contact with questions. This acknowledgment is not an authorization for uses or disclosures that require separate written permission.

☐ I received / was offered the Notice of Privacy Practices.

☐ I would like a paper copy.

For office use only if acknowledgment is not obtained ☐ Patient/representative declined to sign or acknowledge ☐ Emergency/other good-faith reason: _____ Staff initials/date: _____

13. Minor Patient / Personal Representative

Complete only when someone signs for the patient.

Representative's printed name:	Relationship / legal authority:
If patient is under 18: ☐ Parent ☐ Legal guardian	Best phone number:

If I am the parent or legal guardian of a minor patient, I authorize evaluation and chiropractic care described in this packet. I understand an adult authorized by the parent/guardian must accompany the minor as required by clinic policy.

14. One Master Acknowledgment & Signature

By signing below, I certify that the information I provided is complete and accurate to the best of my knowledge; I agree to update the clinic if it changes; I have read and understand Sections 7–13; I had the opportunity to ask questions; and I voluntarily consent to the proposed chiropractic evaluation and care, subject to my right to refuse or withdraw consent. I also accept the self-pay financial terms and acknowledge the Notice of Privacy Practices as indicated above.

Patient or authorized representative signature:	Date:
Printed name:	Patient date of birth:
Doctor / staff witness (optional):	Date:

Important Seek emergency medical care or call 911 for severe or rapidly worsening symptoms. Signing this form does not waive any legal right or release C1 Spine Lab from responsibility for negligent care.